Child & Youth Services Registration Form
(USAREUR Reg 608-10)

Sponsor: (Last name) _____ **(First)** _____ **SSN:** _____

Child: (Last name) _____ **(First)** _____

Data Required by the Privacy Act of 1974

Authority: Title 10, United States Code, section 3012.
Principal purpose (s): To provide child and family program eligibility and background information; sponsor consent for access to emergency medical care; data required by USDA food program.
Routine uses: Information is provided to the attending physician when it is necessary for a child to be taken to medical facility by someone other than the parent. Information on immunizations and medical problems will be used for program-admission-screening procedures. Family income data will be used to determine USDA food program qualification and rate structures.
Disclosure: Disclosure of requested information is voluntary. However, if information is not provided, individuals may not be allowed to participate in Child and Youth Services (CYS) programs.

Declaration of Nondiscrimination

Services will be made available to all children in attendance, without regard to race, color, religion, national origin, ancestry, or gender, within the limits of AR 215-1 and AR 608-10. CYS programs participating in the USDA food program will offer meals without physical segregation of or discrimination against any child regardless of ability.

Parent/Guardian Consent

I _____ (parent/guardian) of _____
give consent for an authorized CYS representative to take my child for care, medical or dental, in an emergency situation when the child's condition represents a serious or imminent threat to his/her life, health, or well-being. I understand that a conscientious effort will be made to notify me before such action. I will pay any expenses incurred. Treatment at an Army medical facility may be provided without additional consent under the provision of AR 40-3, paragraph 2-24b.

Parent/Guardian Permission

I give my permission for my child to use the computers, network and internet at the CYS programs in a responsible manner. My child will agree to follow the posted rules put forth by the local CYS program and will be held responsible for any violation of these rules. As a responsible adult, I agree to convey good standards for Internet use to my child.
*For a complete copy of your center's user agreement and a briefing on our on-line safeguards, contact your local Child & Youth Services Computer Lab staff. ☐ Yes ☐ No

Information

I received the CYS Fee Policy. ☐ Yes ☐ No
I received the CYS Parent Handbook. ☐ Yes ☐ No
I received the USAREUR Child Supervision Policy. ☐ Yes ☐ No

Sole and Dual Military Family Care Plan

I understand that as prescribed by AR 600-20 and AR 608-10, I am required to maintain an accurate Family Care Plan which will remain in the CYS Central Enrollment Registry. I am also aware that the DA Form 5305-R Family Care Plan must be completed within 30 days of enrollment or service may be denied. I understand that I will provide updated information annually or more frequently if necessary to update information.

Sponsor/Parent Signature _____ Date _____

Name of Commander _____ Phone _____

I have reviewed the attached household and family information file. To the best of my knowledge, the information on this form and contained therein is accurate and complete.

Date	**Signature of Parent/Guardian**

INFANT, CHILD AND ADOLESCENT HEALTH ASSESSMENT

DATA REQUIRED BY THE PRIVACY ACT OF 1994

PRINCIPAL PURPOSE: Information is used by DA personnel to: (1) verify child health status of immunization per admission requirements; (2) note special program considerations or restriction on child participation; (3) execute emergency medical procedures for chronic illnesses/conditions; (4) refer child for enrollment in Exceptional Family Member Program. **ROUTINE USES:** No information is disclosed outside DOD. **DISCLOSURE:** Information is voluntary; however, if information is not provided, individuals may not be able to participate in community activities.

NAME OF SPONSOR	DEROS	TELEPHONE (HOME)	TELEPHONE (DUTY)
SPONSOR UNIT ADDRESS	SPONSOR SSN	SPOUSE'S WORK PHONE	

CHILD HEALTH INFORMATION (SPONSOR)

NAME OF CHILD	BIRTH DATE	SEX

HAS YOUR CHILD BEEN UNDER THE SUPERVISION OF A PHYSICIAN? (IF YES EXPLAIN CIRCUMSTANCES AND CURRENT STATUS)

IS CHILD ENROLLED IN EXCEPTIONAL FAMILY MEMBER PROGRAM NO / YES LAST UPDATE:

IMMUNIZATIONS

	DATE	DATE	DATE	DATE	DATE	DATE
DTP/DTaP						TD
HIB						PPD
POLIO						
HEP B				INFLUENZA		
MMR			HEP A			
VARICELLA			OTHER			

MEDICAL HISTORY

	YES	NO		YES	NO
1. ANY HOSPITALIZATION OR OPERATIONS			14. HEAT STROKE OR EXHAUSTION		
2. ALLERGIES TO MEDICINE OR INSECT BITES			15. BROKEN BONES OR SPRAINS		
3. SPEECH OR DEVELOPMENTAL DELAYS			16. JOINT INJURIES (ANKLE / KNEE / WRIST)		
4. VISION PROBLEMS (GLASSES / CONTACTS?)			17. REQUIRED RESTRICTED PHYSICAL ACTIVITY		
5. EAR OR HEARING PROBLEMS			18. FAMILY HISTORY OF DEATH LESS THAN AGE 40		
6. SEIZURES OR CONVULSIONS			19. FAMILY HX OF HEART DISEASE/STROKE < AGE 55		
7. DIZZINESS OR FAINTING WITH EXERCISE			20. FAMILY HX OF HIGH CHOLESTEROL		
8. HEADACHES			21. FAMILY HX OF CANCER		
9. HEAD INJURY OR LOSS OF CONSCIOUSNESS			22. DENTAL OR ORTHODONTIC BRACES		
10. NECK OR BACK INJURY			23. CHICKEN POX (IF YES, DATE:)		
11. ASTHMA OR DIFFICULTY BREATHING			24. ROUTINE OR DAILY MEDICATIONS (LIST BELOW)		
12. HEART OR BLOOD PRESSURE PROBLEMS			25. FEMALES: AGE OF FIRST PERIOD:		
13. CHEST PAIN WITH EXERCISE			26. OTHER PROBLEMS (LIST BELOW):		

IF YOU ANSWER YES TO ANY OF THE ABOVE, PLEASE EXPLAIN:

I GIVE PERMISSION FOR MY CHILD TO HAVE THE FOLLOWING DONE:	YES	NO
1. RECEIVE A PPD (SKIN TEST FOR TUBERCULOSIS)		
2. RECEIVE ANY IMMUNIZATION(S) NECESSARY		
3. RECEIVE A HEALTH SCREEN EXAMINATION FOR SPORTS/SCHOOL/SCOUTS/CDS/OTHER		
4. RECEIVE EMERGENCY MEDICAL CARE DURING SCHOOL OR ORGANIZATIONAL ACTIVITIES INCLUDING CDS		

TYPED OR PRINTED NAME OF PARENT OR GUARDIAN	SIGNATURE OF PARENT OR GUARDIAN

MCEUH OP 34, May 00 (MRRC Approved: 3 May00)

MEDICAL STAFF ASSESSMENT (FILLED OUT BY PHYSICIAN ONLY)

AGE: YRS MOS	HEIGHT: cm.(%ile)	WEIGHT: kgs.(%ile)	BP: / P
	HEIGHT: in.	WEIGHT: lbs.	

VISUAL ACUITY: RIGHT /LEFT /TESTED WITH / WITHOUT LENSES NORMAL ☐ ABNORMAL ☐

	NORMAL	ABNORMAL	N/A	COMMENTS
1. EYES				
2. EARS, NOSE & THROAT				
3. HEARING				
4. MOUTH AND TEETH				
5. NECK (SOFT TISSUES)				
6. CARDIOVASCULAR				
7. CHEST AND LUNGS				
8. ABDOMEN				
9. GENITALIA - HERNIA				
10. SKIN AND LYMPHATICS				
11. NECK				
12. SPINE - SCOLIOSIS				
13. EXTREMITES				
14. NEUROLOGICAL				

15. SEXUAL MATURITY RATING: BREASTS> PUBIC HAIR> MALE GENITAL> FEMALE GENITAL>

BASED ON THIS HX & PX EXAM, THE FOLLOWING ABORMALITIES WERE FOUND AND MAY NEED TREATMENT:

ANTICIPATORY GUIDANCE (CHECK ITEMS DISCUSSED)

☐	NUTRITION	☐	DENTAL CARE	☐	HEADSS	☐	
☐	AGE APPROPRIATE SAFETY	☐	BEHAVIOR	☐		☐	
☐	DEVELOPMENT	☐	RISK FACTORS	☐		☐	

PARTICIPATION RECOMMENDATIONS

☐ NORMAL SCHOOL ACTIVITIES INCLUDING PE

☐ CHILD DEVELOPMENT / YOUTH SERVICES

☐ COLLISION SPORTS

☐ CONTACT SPORTS

☐ NON-CONTACT SPORTS

☐ SCOUTS

THIS STUDENT HAS HEALTH PROBLEMS WHICH WOULD PROHIBIT HIM OR HER FROM PARTICIPATING IN COMPETITIVE ATHLETICS:

☐ NO

☐ YES

THE FOLLOWING HEALTH PROBLEMS SHOULD BE EVALUATED OR TREATED PRIOR TO PARTICIPATING IN COMPETITIVE SPORTS:

THIS DOCUMENT IS VALID FOR 1 YEAR FROM DATE INDICATED BELOW

DATE PHYSICIAN STAMP PHYSICIAN SIGNATURE

SPECIAL NEEDS/CHILD PLACEMENT QUESTIONNAIRE

Welcome to USAREUR Child/Youth Services programs! If your child should have a special need, prior knowledge will allow us to make appropriate adjustments to our program and provide training to the staff before your child's first day.

Child's Name:_____ Date of Birth: _____

Center/Program:_____ Today's Date: _____

1. Does your child have any of the following conditions?	YES	NO		YES	NO
Developmental delays, explain:			Asthma/Respiratory Problems		
Visual Problems/Blindness (Do not check this box if your child only wears glasses)			Speech/Language Delays		
Hearing Problems (Check this box if your child has had Tubes placed) Explain:			Allergic Reactions Explain:		
Physical Disability. Explain:			Behavioral/Conduct Concerns		
Sickle-Cell Disease (Do not check this box if your child Has only Sickle Cell Trait)			Heart Problems (Do not mark this box if your child has a functional or innocent heart murmur)		
Kidney Problems. Explain:			Diabetes		
Epilepsy/Seizures			Attention Deficit/Hyperactivity (ADHD/ADD)		
Autism/PDD			Other(s) Please Specify:		

2. Is your child taking medication for his/her condition, if so please specify:

3. Is your child receiving any services from EDIS (formally EFMD) Early Intervention, CAPS or Pediatric Behavioral Medicine?
___Yes___No If yes, which agency and please explain:

___Yes ___No Is your child on an IEP or an IFSP?

4. Is your child enrolled in a DODDS Developmental Preschool? ___Yes ___No If yes please explain:

5. Is your child enrolled in an Exceptional Family Member Program (EFMP)? ___Yes ___No If yes please explain:

_____ _____/_____

SIGNATURE OF PARENT/SPONSOR/GUARDIAN HOME & DUTY PHONE

_____

PRINT NAME (state rank if applicable)

For PRIVACY ACT STATEMENT see DA Form 4719-R, July 1989.

****

(OFFICE USE ONLY) Date received:_____

History of Special Need/Medical Condition: Telephone contact date & time_____

Recommendation: a. Admit/No Significant modifications needed b. Admit w/Care Plan Training date _____ c. Hold & schedule SNRT Date/Time _____

_____ _____ _____

CYSD/CH NURSE Date Yes/No SPECIAL NEEDS DIRECTOR Date Yes/No CYSD CHIEF Date Yes/No

Copy to CYSD ☐ Copy to EFMP ☐ Copy to CHN ☐ SPS - Log entry ☐ SPS – W/L, place in child's file ☐